

MEDICAL RECORD -- SUPPLEMENTAL MEDICAL DATA

For use of this form, see AR 40-400; the proponent agency is the Office of the Surgeon General.

REPORT TITLE

HEPATITIS C SCREENING

OTSG APPROVED (Date)

1. Hepatitis C is transmitted primarily by contaminated blood; i.e., blood transfusions, contaminated needles, and accidental sticks with contaminated sharp objects. The following are possible sources of hepatitis C virus (HCV) infection. If you can answer "yes" on any of the risk factors listed in paragraph 2 below, you should receive a simple blood test to determine if you could have hepatitis C. If you consider yourself at risk, based on an exposure to a possible source of hepatitis C virus, you should have a simple blood test for HCV. You will not be asked to identify any specific risk factors to justify HCV infection. If the test is positive you will receive a medical evaluation to confirm HCV infection, to determine your need for specific treatments, and to be provided counseling on lifestyle modifications and steps to protect others from infection.

2. Risk factors:

- a. You have received a transfusion of blood or blood products before 1992.
- b. You have ever injected illegal drugs into yourself, including one used many years ago.
- c. You have received clotting factor concentrates produced before 1987.
- d. You have chronic, long term hemodialysis.
- e. You have been told that you have persistent abnormal liver enzyme tests (alanine aminotransferase) or an unexplained liver disease.
- f. You have received an organ transplant before July 1992.
- g. You have had a needle stick, sharps, or mucosal exposure to potentially HCV-infected blood as part of your occupational duties and have not been previously evaluated for HCV infection.

3. If the blood test is positive, you will receive a medical evaluation to confirm HCV infection, determine your need for specific treatments, and be provided counseling on lifestyle modifications and steps to protect others from infection.

4. Please make a selection from the two options below, then sign and date in the spaces indicated.

- ☐ NO. I do not want to be tested for hepatitis C.
- ☐ YES. I want to be tested for hepatitis C.

Signature: _____ Date: _____

(Continue on reverse)

PREPARED BY (Signature & Title)

DEPARTMENT/SERVICE/CLINIC

DATE

PATIENT'S IDENTIFICATION (For typed or written entries give: Name--last, first, middle; grade; date; hospital or medical facility)

- ☐ HISTORY/PHYSICAL ☐ FLOW CHART
- ☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)
- ☐ DIAGNOSTIC STUDIES
- ☐ TREATMENT